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UNIVERSAL HEALTH CARE/NASHVILLE	1022 EASTERN AVENUE NASHVILLE, NC 27856

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D 259	10A NCAC 13F .0802(a) Resident Care Plan 10A NCAC 13F .0802 Resident Care Plan (a) An adult care home shall assure a care plan is developed for each resident in conjunction with the resident assessment to be completed within 30 days following admission according to Rule .0801 of this Section. The care plan is an individualized, written program of personal care for each resident. This Rule is not met as evidenced by: Based on staff interview and record review the facility failed to develop care plans for falls and elopement which resulted in a fall for 1 of 3 sampled residents (Resident #3) who experienced multiple falls in the assisted living secure unit. Findings included: Resident #3 was admitted to the facility (assisted living secure unit) on 06/20/14 with documented diagnoses which included frequent falls. A 06/21/14 nurse's note documented Resident #3 ambulated out the side door of the secure unit dining room, and fell onto the concrete pad of an enclosed patio. Resident #3's 06/24/14 Adult Care Home Personal Care Physician Authorization and Care Plan documented the resident exhibited wandering behavior in the Assessment: Mental Health and Social History section. Instructions in the Care Plan section of the assessment documented, "If the assessment indicates the resident has medically related personal care needs requiring assistance, show the plan for providing care." In the Care Plan: Activities of Daily Living (ADL) section, the unit manager documented "(Resident #3) wanders @ (at) times" in relation to ambulation/locomotion.	D 259	D259 Resident #3 was re-assessed by AL Manager for fall and elopement risk. Care plan was updated with appropriate interventions. Memory Care staff was re-educated by the AL Manager on Resident #3 regarding risk needs including falls and elopement, current interventions and updated care plan on 8/2/14. Audible alarms were placed in Memory Care on the two exit doors leading to the patio and the two internal doors exiting into the facility as an added elopement safety precaution on 8/5/14. Each shift the Med Tech in Memory Care is responsible for checking each alarm to ensure it is working properly. AL Manager will check the audit sheets daily x 2 weeks; then weekly x 2 weeks; then monthly x 2 months to ensure Med Techs are documenting the alarm checks. Incident reports for Resident #3 of falls or elopement will be brought to the morning clinical meeting to be reviewed by the IDT to ensure appropriate interventions are in place, care plan updated and staff trained on care expectations. Started 8/4/14 and	8/21/14

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D 259	Continued From page 1 However, no care plan was developed for falls or elopement. A 07/17/14 7:15 PM nurse's note documented Resident #3 fell onto the floor while ambulating. A 07/27/14 6:30 PM nurse's note documented Resident #3 slid onto the floor while ambulating. At 10:45 AM on 08/01/14 the administrator and Nurse #2 (Minimum Data Set nurse) stated a care plan consisted of a problem, a goal, and interventions for addressing the problem. They reported care plans regarding falls and elopement were necessary for Resident #3, but had not been developed.	D 259	on-going. An audit was started 8/4/14 on current residents in both Memory Care and Assisted Living by the AL Manager for falls and elopement risk. Care plans were reviewed to ensure that Care Plans were completed & updated with current care needs to include fall & elopement risks. Audit will be completed by 8/27/14. Starting 08/27/14,the Social Worker and/or Administrator will review 5 current residents in Memory Care weekly x 4 weeks to ensure assessments and care plans are appropriately developed to meet the individual needs of all current Memory Care residents. The AL Manager and/or DON will review 10 current residents in AL weekly x 4 weeks to ensure assessments and care plans are appropriately developed to meet the individual needs of all current AL residents. Audible alarms were placed in Memory Care on the two exit doors leading to the patio and the two internal doors exiting into the facility as an added elopement safety precaution on 8/5/14. Each shift the Med Tech in Memory Care is responsible for checking each alarm to ensure it is working properly. Al Manager will check the audit sheets daily x 2 weeks; then weekly x 2 weeks; then monthly x 2 months to ensure Med Techs are documenting the alarm checks. Incident reports of falls, elopement or resident events will be brought to the morning clinical meeting to be reviewed by the IDT to ensure appropriate	

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D 259	Continued From page 2	D 259	interventions are in place, care plans updated and staff trained on care expectations started 8/5/14 and on-going. A weekly Standards of Care meeting is in place to review weekly falls, elopements and resident events, current interventions and updated care plans. Started 8/11/14 and on-going. The AL Manager will bring the Standards of Care information to the monthly QA meeting for review by committee. Started 8/19/14 and on-going. Nursing staff including licensed nurses, medication technicians and CNAs will receive re-education by the Administrator and the AL Manager on 8/26/14 and 8/28/14. Education will include Safety & Falls Prevention, falls investigation, fall interventions, elopement risk and interventions, the supervision of at risk residents, updating and utilizing resident care plans. New admission residents in the AL or Memory Care will be assessed by the AL Manager and/or DON for elopement and falls risk and a care plan will be developed to meet each care need. The Social Worker and/or Administrator will review newly admitted residents weekly x4 weeks; then monthly x 2 months to ensure assessments and care plans are appropriately developed to meet the individual needs of the resident.	

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D 260	Continued From page 3	D 260		
D 260	10A NCAC 13F .0802(b) Resident Care Plan 10A NCAC 13F .0802 Resident Care Plan (b) The care plan shall be revised as needed based on further assessments of the resident according to Rule .0801 of this Section This Rule is not met as evidenced by: Based on staff interview and record review the facility failed to update the falls care plan for 1 of 3 sampled residents (Resident #2) who experienced multiple falls in the assisted living secure unit. Findings included: Resident #2 was admitted to the facility on 08/23/11. The only care plan related to falls which Resident #2 experienced in the assisted living secure unit was dated 06/29/12, and identified the problem "Potential for injury: history of falls, impaired vision." Interventions to this plan included "toileting assistance routinely", "make sure resident's shoes are well fitting with non-slip shoes/non-skid socks", "encourage rest periods", and "provide verbal reminders to resident to call when needing assistance". A 12/18/13 nurse's note documented Resident #2 was ambulating on the secure unit when she tripped, fell, and fractured her knee cap. 12/18/13 therapy notes documented the resident was to begin using a walker during ambulation. A 03/10/14 nurse's note documented Resident #2 fell out of bed. 03/14/14 computed tomography (CT) results documented the resident experienced a fracture of her right hip due to this fall.	D 260	D 260 Resident #2 was discharged. An audit was started 8/4/14 on current residents in both Memory Care and Assisted Living by the AL Manager for falls and elopement risk. Care plans were reviewed to ensure that Care Plans were completed & updated with current care needs to include fall & elopement risks. Audit will be completed by 8/27/14. Starting on 08/27/14, the Social Worker and/or Administrator will review 5 current residents in Memory Care weekly x 4 weeks to ensure assessments and care plans are appropriately developed to meet the individual needs of all current Memory Care residents. The AL Manager and/or DON will review 10 current residents in AL weekly x 4 weeks to ensure assessments and care plans are appropriately developed to meet the individual needs of all current AL residents. Incident reports of falls, elopement or resident events will be brought to the morning clinical meeting to be reviewed by the IDT to ensure appropriate interventions are in place, care plans updated and staff trained on care expectations Started 8/5/14 and on-going.	8/21/14

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D 260	Continued From page 4 A 05/07/14 nurse's note documented Resident #2 slipped, was caught by a nursing assistant, but sustained a laceration to the side of her eye. A 06/05/14 nurse's note documented Resident #2 was found on the floor with a hematoma to her left eyebrow. A 07/06/14 nurse's note documented Resident #2 fell out of bed. 07/21/14 x-ray results documented the resident experienced a fracture of her left hip due to this fall. At 10:45 AM on 08/01/14 the administrator and Nurse #2 (Minimum Data Set nurse) stated Resident #2's care plan should have been updated to reflect actual falls sustained on 12/18/13, 03/10/14, 05/07/14, 06/05/14, and 07/06/14 which resulted in injury. They also commented any new interventions such as use of the walker should have been added to the care plan.	D 260	A weekly Standards of Care meeting is in place to review weekly falls, elopements and resident events, current interventions and updated care plans. Started 8/11/14 and on-going. The AL Manager will bring the Standards of Care information to the monthly QA meeting for review by committee. Started 8/19/14 and on-going. Nursing staff including licensed nurses, medication technicians and CNAs will receive re-education by the Administrator and the AL Manager on 8/26/14 and 8/28/14. Education will include Safety & Falls Prevention, falls investigation, fall interventions, elopement risk and interventions, the supervision of at risk residents, updating and utilizing resident care plans. New admission residents in the AL or Memory Care will be assessed by the AL Manager and/or DON for elopement and falls risk and a care plan will be developed to meet each care need. The Social Worker and/or Administrator will review newly admitted residents weekly x4 weeks; then monthly x 2 months to ensure assessments and care plans are appropriately developed to meet the individual needs of the resident.	
D 270	10A NCAC 13F .0901(b) Personal Care and Supervision 10A NCAC 13F .0901 Personal Care and	D 270		8/21/14

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D 270	Continued From page 5 Supervision (b) Staff shall provide supervision of residents in accordance with each resident's assessed needs, care plan and current symptoms. This Rule is not met as evidenced by: Type B Violation Based on medical director interview, staff interview, and record review the facility failed to place interventions in place to prevent the reoccurrence of falls for 2 of 3 residents (Resident #2 and #3) who experienced multiple falls in an assisted living secure unit. Findings included: 1. Resident #2 was admitted to the facility on 08/23/11. Her documented diagnoses included osteopenia, anemia, chronic obstructive pulmonary disease, diabetes, and hypertension. The most recent assisted living nursing assessment, a 06/29/12 Adult Care Home Personal Care Physician Authorization and Care Plan, documented Resident #2 was alert and oriented to person and place, was sometimes disoriented, and was forgetful/requiring reminders. A 03/09/14 midnight nurse's note documented Resident #2 fell out of bed and began experiencing pain in her right hip and leg. The resident's medication administration record (MAR) documented the resident received as needed (PRN) Tylenol 650 milligrams (mg) every (Q) four hours until 03/14/14 when a nurse's note documented she went to the hospital for computed tomography (CT).	D 270	D270 Resident #2 was discharged from the facility. Resident #3 was re-assessed by AL Manager for fall and elopement risk. Care plan was updated with appropriate interventions.. Memory Care staff was re-educated by the AL Manager on Resident #3 regarding risk needs including falls and elopement, current interventions and updated care plan on 8/2/14. An audit was started 8/4/14 on current residents in both Memory Care and Assisted Living by the AL Manager for falls and elopement risk. Care plans were reviewed to ensure that Care Plans were completed & updated with current care needs to include fall & elopement risks. Audit will be completed by 8/27/14. Starting 08/27/14, the Social Worker and/or Administrator will review 5 current residents in Memory Care weekly x 4 weeks to ensure assessments and care plans are appropriately developed to meet the individual needs of all current Memory Care residents. The AL Manager and/or DON will review 10 current residents in AL weekly x 4 weeks to ensure assessments and care plans are appropriately	

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D 270	Continued From page 6 03/14/14 CT results documented Resident #2 had a "nondisplaced, incomplete fracture through the greater trochanter of the right proximal femur." A 05/07/14 5:30 AM nurse's note documented Resident #2 sustained a laceration to the right eyebrow when a nursing assistant (NA) caught her as she slipped leaving the bathroom. A 06/15/14 11:00 AM nurse's note documented Resident #2 was found sitting upright on the floor of another resident's room. The resident experienced a hematoma around the left eyebrow. A 07/06/14 4:40 AM nurse's note documented Resident #2 rolled out of bed onto the floor. The resident complained of left hip pain, and was sent to the emergency room (ER) for evaluation. A 07/06/14 9:00 AM nurse's note documented Resident #2 returned from the ER where diagnostics determined the resident had not experienced a fracture. The resident returned with no new orders. Nurse's notes documented the resident continued to experience sporadic pain in the left hip which, according to the MAR, was managed effectively by the use of Percocet 5/325 milligrams (mg) every (Q) six hours as needed (PRN). A 07/21/14 9:15 AM nurse's note documented Resident #2 had experienced worsening pain in her back and left hip over the weekend, and x-rays were ordered. 07/21/14 x-ray results documented "sub-acute fracture involves the base of the left femoral neck/left intertrochanteric region."	D 270	developed to meet the individual needs of all current AL residents. Incident report of falls and resident events will be brought to the morning clinical meeting to be reviewed by the IDT to ensure appropriate interventions are in place, care plans updated and staff trained on care expectations. Started 8/4/14 and on-going. The AL Manager will bring the Standards of Care information to the monthly QA meeting for review by committee. Started 8/19/14 and on-going. Nursing staff including licensed nurses, medication technicians and CNAs will receive re-education by the Administrator and the AL Manager on 8/26/14 and 8/28/14. Education will include Safety & Falls Prevention, falls investigation, fall interventions, elopement risk and interventions, the supervision of at risk residents, updating and utilizing resident care plans.	

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D 270	Continued From page 7 At 9:20 AM on 07/31/14 Nurse #1, the supervisor of the assisted living secure unit who reported she had held her current position since the end of May 2014, stated the only interventions she was aware of to help Resident #2 prevent further falls was to remind her to use her rolling walker and to place her in a wheelchair when she became weak. The nurse reported she was unaware of any fall interventions when the resident was in bed. At 10:00 AM on 07/31/14 the administrator stated she realized the analysis of accidents and incidents in assisted living was a problem, and she began working on a plan about three days ago which involved completing incident/accident reports, logging the incidents, discussing them in morning meetings, developing a four-point plan to prevent reoccurrence for those accidents involving injury, and incorporating the analysis of these accidents into the facility's quality assurance (QA) program. She reported this plan was not in place yet, and she was awaiting feedback from corporate on the project. The administrator explained currently the only piece of her plan that was being used in assisted living was the completion of incident/accident reports. At 10:08 AM on 07/31/14 medication aide (MA) #1 stated Resident #2 utilized a rolling walker after a fall in December 2013 (this fall on 12/18/13 resulted in a fractured left knee). She also reported the staff began using a wheelchair for the resident in early 2014 on those days when her legs were weaker. MA #1 commented Resident #2 had always been in a standard bed while in the secure unit. She explained the staff lowered all standard beds to the lowest position at night.	D 270		

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D 270	Continued From page 8 At 11:02 AM on 07/31/14 NA #1 stated there were no fall preventions in place for Resident #2 at night when in bed other than having her standard bed in the lowest position, which was done for all residents in these type beds. She reported the resident was reminded to use a walker and placed in a wheelchair when weak, but these interventions were being utilized prior to her hip fractures. At 4:00 PM on 07/31/14 QA minutes for meetings on 03/27/14, 04/24/14, 05/29/14, and 06/26/14 were reviewed. Falls in assisted living were not included in falls analysis, no individual residents who experienced falls in assisted living were discussed, and no four-point plans were developed for any assisted living residents who experienced falls with injury. At 4:23 PM on 07/31/14 MA #2 stated some residents in the secure unit had low beds, mats, and one resident had an alarm. However, she reported Resident #2 was in a standard bed during her stay on the secure unit. She commented it was a challenge to get Resident #2 to use her walker, and sometimes the resident was placed in a wheelchair when she was weak. MA #2 explained the walker and wheelchair had been in place for the resident probably for at least six months. At 6:12 PM on 07/31/14 the medical director stated it was important to discuss falls experienced by residents in skilled nursing and assisted living beds during QA meetings which he attended. He explained this helped maintain a continuity of care in the building. According to the medical director, individual residents who experienced falls were discussed during QA	D 270		

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D 270	Continued From page 9 meetings, and fall interventions were determined. However, he stated he was unsure if any of these residents resided in assisted living beds. 2. Resident #3 was admitted to the facility (assisted living secure unit) on 06/20/14. The resident's documented diagnoses included frequent falls, vitamin D deficiency, glaucoma, anemia, and history of deep venous thrombosis. A 06/21/14 nurse's note documented Resident #3 ambulated out the side door of the secure unit dining room, and fell onto the concrete pad of an enclosed patio. The resident's 06/24/14 Adult Care Home Personal Care Physician Authorization and Care Plan documented Resident #3 suffered from "depressing dementia", was sometimes disoriented, and experienced significant loss of memory/required direction. A 07/17/14 7:15 PM nurse's note documented Resident #3 fell onto the floor while ambulating, and sustained a knot to the right side of her head. A 07/27/14 6:30 PM nurse's note documented Resident #3 slid onto the floor while ambulating. Diagnostics documented the resident was negative for fracture. On 07/31/14 at 9:20 AM Nurse #1, at 10:08 AM medication aide (MA) #1, at 11:02 AM nursing assistant (NA) #1, and at 4:23 PM MA #2 all stated the only fall intervention for Resident #3 was the four-pronged cane the resident was admitted with. They all reported they were unaware of any resident eloping through the dining room door on the unit.	D 270		

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D 270	Continued From page 10 At 10:00 AM on 07/31/14 the administrator stated she realized the analysis of accidents and incidents in assisted living was a problem, and she began working on a plan about three days ago which involved completing incident/accident reports, logging the incidents, discussing them in morning meetings, developing a four-point plan to prevent reoccurrence for those accidents involving injury, and incorporating the analysis of these accidents into the facility's quality assurance (QA) program. She reported this plan was not in place yet, and she was awaiting feedback from corporate on the project. The administrator explained currently the only piece of her plan that was being used in assisted living was the completion of incident/accident reports. At 4:00 PM on 07/31/14 QA minutes for meetings on 03/27/14, 04/24/14, 05/29/14, and 06/26/14 were reviewed. Falls in assisted living were not included in falls analysis, no individual residents who experienced falls in assisted living were discussed, and no four-point plans were developed for any assisted living residents who experienced falls with injury. At 6:12 PM on 07/31/14 the medical director stated it was important to discuss falls and other incidents such as elopements experienced by residents in skilled nursing and assisted living beds during QA meetings which he attended. He explained this helped maintain a continuity of care in the building. According to the medical director, individual residents who experienced falls were discussed during QA meetings, and fall interventions were determined. However, he stated he was unsure if any of these residents resided in assisted living beds. He commented he did not recall discussion about any elopements	D 270		

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D 270	Continued From page 11	D 270		

from the assisted living secure unit during the QA meetings he attended.

At 5:30 AM on 08/01/14, during a telephone interview, MA #3 stated on 06/21/14 when she did her initial tour of residents at the start of her 11 PM - 7 AM shift Resident #3 was in bed. She reported she went into the nursing station/office to get her medication cart ready, and as she was exiting the office she noticed some movement outside the unit dining room. According to MA #3, no more than 15 minutes had elapsed seeing Resident #3 in bed. However, she explained that she found Resident #3 on the concrete pad outside the door where she had fallen. The MA reported a full body assessment was completed, and the resident sustained no injuries. She stated she informed the on-coming MA about the incident at the end of her shift and documented it on the 24-hour report. However, MA #3 commented she was unsure how this information got passed onto staff who worked in the unit during the week (Resident #3's elopement/fall occurred on the weekend).

At 8:50 AM on 08/01/14 the unit dining room door was inspected. The door opened from the inside using a push bar, and no alarm sounded when the door was opened. The door had full upper and lower glass panels in it, and the patio was visible through the door. The door opened out onto an open-air patio fully enclosed by fencing. Once outside, the door could not be reopened for re-entry into the building unless someone inside the unit opened it. There were two sets of double doors in and out of the unit, and a door at the end of a hall which entered out onto the far end of the patio.

At 11:42 AM on 08/01/14 MA #1 stated all

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	NH0500	A. BUILDING: _____ B. WING _____	C 08/01/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
UNIVERSAL HEALTH CARE/NASHVILLE	1022 EASTERN AVENUE NASHVILLE, NC 27856

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 270	Continued From page 12 residents who went out onto the patio had to be supervised by staff. She reported several residents from the unit had opened the dining room door and exited by themselves, but did not fall, and were immediately observed by staff who stayed outside with them or brought them back inside. MA #1 explained starting before breakfast and continuing until after supper as many of the unit residents were kept in the dining/activity room where they could be supervised by at least one staff member at all times. At 11:50 AM on 08/01/14 Nurse #1, the unit supervisor, confirmed that no residents were to be out on the patio without staff supervision. She also reported Resident #3 was assessed as exhibiting wandering tendencies upon admission to the secure unit. However, she commented there was no documentation or observations of the resident exhibiting exit-seeking behaviors until 06/21/14.	D 270		
D 451	10A NCAC 13F .1212(a) Reporting of Accidents and Incidents 10A NCAC 13F .1212 Reporting of Accidents and Incidents (a) An adult care home shall notify the county department of social services of any accident or incident resulting in resident death or any accident or incident resulting in injury to a resident requiring referral for emergency medical evaluation, hospitalization, or medical treatment other than first aid. This Rule is not met as evidenced by: Based on staff interview and record review the facility failed to report falls with injury to social services for 1 of 3 sampled residents (Resident	D 451	D 451 The Administrator will ensure that incidents and accidents as required per	8/21/14

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D 451	Continued From page 13 #2) who experienced multiple falls in the facility's assisted living secure unit. Findings include: Resident #2 was admitted to the facility on 08/23/11. A 12/18/13 nurse's note documented Resident #2 was ambulating on the secure unit when she tripped, fell, and fractured her knee cap. A 03/10/14 nurse's note documented Resident #2 fell out of bed. 03/14/14 computed tomography (CT) results documented the resident experienced a fracture of her right hip due to this fall. A 05/07/14 nurse's note documented Resident #2 slipped, was caught by a nursing assistant, but sustained a laceration to the side of her eye. A 06/05/14 nurse's note documented Resident #2 was found on the floor with a hematoma to her left eyebrow. A 07/06/14 nurse's note documented Resident #2 fell out of bed. 07/21/14 x-ray results documented the resident experienced a fracture of her left hip due to this fall. At 10:45 AM on 08/01/14 the corporate nursing consultant and administrator stated Resident #2's falls with injury on 12/18/13, 03/10/14, 06/05/14, and 07/06/14 had not been reported to social services. They explained that the facility had been following skilled nursing guidelines for accidents/incidents experienced in the assisted living secure unit by submitting 24-hour and 5-day reports to the state for injuries of unknown origin.	D 451	regulations will be sent to the local DSS via fax as of 08/02/14 and on-going. The AL Manager has been educated on the requirement and will immediately report to the Administrator any resident in Memory Care or AL experiencing an accident/incident which requires reporting to DSS. Started 08/02/14 and on-going. All Incident report of falls and resident events will be brought to the morning clinical meeting to be reviewed by the IDT to ensure appropriate interventions are in place, care plans updated and staff trained on care expectations. The Administrator will obtain copies of any incidents in Memory Care or AL that need to be reported to DSS per regulations. Started 8/4/14 and on-going. The Administrator will keep a log of fax confirmations of all accident/incidents notifications sent to DSS as of 08/02/14 and on going.-	